STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 89621-001**

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
this 3rd day of July 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On May 6, 2008, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* On May 13, 2008, the Commissioner accepted the request.

The issue in this external review can be decided by a contractual analysis. The contract here is the certificate of coverage (the certificate) issued by Physicians Health Plan of Mid-Michigan (PHP). The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner is a member of PHP. Her health care benefits are defined in the certificate. The certificate provides for both network and non-network benefits. To obtain network benefits, the care must be provided by in-network providers. Care from non-network providers may be covered

but it generally comes with a higher out-of-pocket cost for the PHP member. The certificate permits in-network-level benefits for non-network services when the services are not available from network providers or for emergency services.

On August 27, 2007, the Petitioner had an appointment with XXXXX, MD, and also received services from XXXXX. Dr. XXXXX and XXXXX are not in PHP's network. When the Petitioner requested coverage for the services, PHP denied coverage at the network level but approved coverage at the non-network level, which required the Petitioner to meet a $200.00 deductible and then pay a copayment of 20% of eligible expenses.

The Petitioner appealed but PHP maintained its determination. The Petitioner exhausted PHP's internal grievance process and received its final adverse determination dated April 23, 2008.

III
ISSUE

Did PHP properly deny coverage for the Petitioner's services at the in-network level?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's mother says that after making the appointment with Dr. XXXXX she contacted PHP to see if a referral was needed. She says she was advised that a referral was not required and there should be no problem with having the visit covered.

The Petitioner argues that coverage should be at the in-network level because PHP's representatives inadequately advised her about services from a non-network provider and never told her that the services would be covered at the non-network level.

Physicians Health Plan's Argument

In its April 23, 2008, final adverse determination, PHP said it covered the Petitioner's services at the non-network level because "the services are available within the PHP network."

PHP cited these provisions in the certificate as the basis for its decision:

Section 1: What's Covered – Benefits

Accessing Benefits
You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or non-Network Physician or other provider. For details about when Network Benefits apply see Section 3: Description of Network and Non-Network Benefits.

* * *

Eligible Expenses
Eligible Expenses are the amount we determine that we will pay for Benefits. For a complete definition of Eligible Expenses that describes how we determine payment, see Section 10: Glossary of Defined Terms. For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

* * *

SECTION 3: Description of Network and Non-Network Benefits

Network Benefits
Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are

- Provided by or under the direction of a Network Physician in a Network Physician's office or at a Network facility.

- Emergency Health Services.

- Urgent Care Center services.

* * *

Health Services from Non-Network Providers Paid as Network Benefits
If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-Network provider without verifying in advance that we have approved your visit, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which Benefits are provided under the Policy.

> **Non-Network Benefits**
> Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services which are any of the following:
>
> - Provided by a non-Network Physician or other non-Network provider.
> - Provided at a non-Network facility.

PHP says the care the Petitioner received was available from network providers and that the Petitioner did not follow the requirements of the certificate in order to have non-network care covered at the network level – she did not have the care authorized in advance.

Based on the language in the certificate, PHP believes that the services from Dr. Peimer and XXXXX were appropriately covered at the non-network level.

Commissioner's Review

The certificate has two levels of benefits -- the Petitioner can receive medically necessary and covered services from either network or non-network providers. However, network benefits are covered by PHP at a higher level than non-network benefits. Services from non-network providers may be covered at the network level only under certain circumstances (e.g., when they are for urgent or emergency care, when PHP does not have the needed care available within its network, or when they are authorized in advance by PHP).

The Petitioner has not asserted that the care she sought from Dr. XXXXX and XXXXX was not available within PHP's network, nor has she argued that she had prior authorization. Instead, it is her contention that she was ill-advised about her benefits when she contacted PHP's customer service representative. The Petitioner said she called PHP to see if a referral to Dr. XXXXX was needed. According to the certificate, no referral for outpatient surgery was needed even though Dr. XXXXX is not in PHP's network. However, as a non-network provider, Dr. XXXXX's services would be covered at the non-network level of benefits.

The Commissioner is not able to determine what was said in telephone conversations. Moreover, even if it were possible on this record to assign fault for any alleged miscommunication,

a resolution of that issue cannot be the basis of a PRIRA decision because the Commissioner is without authority to order equitable relief. Under PRIRA, in this case, the Commissioner is limited to determining whether PHP incorrectly denied benefits under the terms and conditions of the certificate.

The certificate is clear that non-network services are paid at a lower level than network benefits. Since there is no assertion or documentation that would show that the services the Petitioner received were not available within PHP's network or that PHP approved the services in advance, PHP appropriately covered those services at the non-network level (80% of eligible expenses after satisfaction of the deductible).

The Commissioner finds that PHP is not required to cover any services from Dr. Peimer and MGH at the network level.

V
ORDER

The Commissioner upholds PHP's final adverse determination of April 23, 2008. PHP is not required to provide network level coverage for the Petitioner's services from non-network providers Dr. XXXXX and XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.